

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## **I. DISPUTE**

1. a. Whether there should be additional reimbursement of \$494.40 for date of service 03/02/01.
- b. The request was received on 02/27/02.

## **II. EXHIBITS**

1. Requestor, Exhibit 1:
  - a. TWCC-60 and undated letter
  - b. HCFA(s)-1500
  - c. EOB(s)
  - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
  - a. TWCC-60 and Response to a Request for Dispute Resolution dated 07/23/02
  - b. HCFA(s)1500
  - c. EOB(s)
  - d. Medical records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. The Commission case file did not contain a Notice of Medical Dispute Resolution sign sheet. The dispute packet did not include a 14 day response from the provider or the carrier. The Commission requested the 14 day additional information response from the provider on 04/17/02, but the provider did not respond, therefore, the carrier did not have the opportunity to submit it's 14 day response. Telephone contact was made with the carrier representative on 07/22/02. She confirmed that the carrier did not receive any additional information since the carrier submitted it's initial on 02/27/02. The carrier was given 14 days from 07/23/02 to submit it's 14 day response. The response was received by the Commission on 07/23/02, therefore, the response is deemed timely.
4. The Commission's request dated 04/17/02 information within 14 days from the provider is reflected as Exhibit III of the Commission's case file.

### III. PARTIES' POSITIONS

1. Requestor: Undated letter:  
“76499-27-22....(Carrier) is reimbursing 20% more for technical portion of another codes [sic] value (76000-\$88.00)...Per Spine Treatment Guideline (T)(i) ESI must be under fluoroscopic control....Neither the...carrier nor the carrier’s agent shall change a billing code’s value unless the...carrier contacts the sender....A C-arm that is used to document the Epiduragram during the Epidural Steroid Injection has a base cost [sic] \$100,000.00, which is calibrated by a Physicist once a year...service contract averages out to \$7,000.00 per year....We are also paying for the expense of the film. This is why we feel \$0.00 for our technical portion for Fluoroscopic Guidance is inaccurate....Epiduragram documented in operative report...”
2. Respondent: Letter dated 7/23/02:  
“THE PROCEDURES 74999 WERE BILLED, UNLISTED RADIOLOGY PROCEDURE....\*\*\*\*\* THE CARRIER DETERMINED THAT, SINCE THE PROVIDER INSISTS THIS PROCEDURE IS ‘OVER AND ABOVE’ A FAIR AND REASONABLE AMOUNT OF \$105.60(76000-27 MAR \$88.00 PLUS 20%, FOR A TOTAL OF \$105.60). **PLEASE NOTE ATTACHED EXAMPLES OF THIS PROVIDER’S BILLING – ORIGINALLY, THE PROVIDER BILLED WITH 76000-27 AND, AT TIMES, OTHER XRAYS CODES, AND FEE WAS PAID. THE PROVIDER THEN BILLED ‘UNLISTED CODES’ FOR \$300.00 EACH, WHICH HAS NOW CHANGED TO \$350.00 AND \$300.00 FOR 76499-27, AND IN ONE CASE BILLED \$650.00 FOR ONLY ONE UNLISTED SERVICE....THE PROVIDER CONTENDS THAT THEY UTILIZE ‘NEW, HIGH-TECH’ EQUIPMENT-HOWEVER, THE FEE GUIDELINES DO NOT INDICATE THAT PROVIDERS MAY BE REIMBURSED AT A HIGHER RATE WHEN USING NEWER EQUIPMENT.**”

### IV. FINDINGS

1. Based on Commission Rule 133.307 (d)(1&2), the only date of service eligible for review is 03/02/01.
2. The carrier EOB denials are:  
“M – REDUCED TO FAIR AND REASONABLE.”;  
“D – REIMBURSEMENT FOR UNILATERAL OR BILATERAL PROCEDURES IS BEING WITHHELD AS THE MAXIMUM NUMBER OF OCCURENCES FOR A SINGLE DATE OF SERVICE OR MAXIMUM LIFETIME FOR THE CLAIM HAS BEEN EXCEEDED”. Rule 133.304 (c) states, “The explanation of benefits shall include the correct payment exception codes required by the Commission’s instructions...” The carrier failed to meet Rule 133.304 (c) by denial code “D”.

3. The provider billed a total of \$600.00 for date of service.
4. The carrier reimbursed the provider a total of \$105.60 for date of service.
5. The total amount in dispute for date of service is \$494.40.
6. The following table identifies the disputed services and Medical Review Division's rationale:

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DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MARS	REFERENCE	RATIONALE:
03/02/01	76499-27-22	\$300.00	\$105.60	M	DOP	Texas Workers' Compensation Commission Act & Rules, Sec. 413.011(d); MFG, GI (III); (I) (A&B); CPT & modifier descriptors; TWCC Advisory 97-01	The CPT descriptor states, "Unlisted diagnostic radiologic procedure." The medical documentation indicates that the provider is billing for fluoroscopic guidance (fluoroscopy). The MFG GI (I)(A) states, "... (TWCC) has incorporated usage of the ... (AMA's) 1995 ... (CPT) codes". The MFG has CPT code 76000 which has the descriptor "Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg. cardiac fluoroscopy)". The CPT code 76000 is sufficiently descriptive of the procedure performed and should have been used. The MAR value of 76000-27 is \$88.00. (The carrier reimbursed the provider \$88.00 plus 20% which equals \$105.60). The MFG, GI (III) (A) states, "(DOP) in the ... (MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill." The provider failed to meet the DOP criteria. Therefore, no additional reimbursement is recommended.
03/02/01	76499-27	\$300.00	\$0.00	D	DOP	MFG, GI (III) (A), CPT & modifier descriptors; TWCC Advisory 97-01	The TWCC Advisory 97-01 states, "... When videofluoroscopy or fluoroscopy is performed with a myelogram or discogram, <b>such procedures</b> (emphasis added) are considered part of the service and should not be billed separately. The procedure in dispute is an epidurogram and is a procedure that should not be reimbursed separately. The MFG, GI (III) (A) states, "(DOP) in the ... (MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill." The provider failed to meet the DOP criteria. Therefore, no reimbursement is recommended.
<b>Totals</b>		\$600.00	\$105.60				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 23rd day of July 2002.

Donna M. Myers, B.S.  
Medical Dispute Resolution Officer  
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.